# Patient Registration

***Please print clearly and complete ALL areas***

**Last _____ First _____ Middle _____**
**(Name of patient)**

**SSN ___/___/____ Date of Birth ___/___/____**

**Sex____ Race_____ Language _____ Marital Status _____**

**Address _____ Apt ____**

**City _____ State _____ Zip _____**

**Phone (Home) (___) ___-____ (Work) (____) ___-____**

**Parent or Guardian_____**
**(Please complete if patient is less than 18 yrs.)**

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**Do you have medical insurance? YES NO MEDICAID YES NO**

**If yes, please show insurance card. MEDICARE YES NO**

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***Voter Registration* – Are you a registered voter? YES NO**
**If NO - Do you want to register to vote? YES NO**
**(Must be 18 or older)**

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**Emergency Contact-Last Name _____ First Name _____**

**Phone (___) ___-____Contact Address _____**

**City _____ Zip _____ Contact Relationship _____**

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**Have you been seen in this clinic or Health Department before? Yes No**

**Have other family members been seen in the health department (family practice (adults and children), family planning, etc.) before? Yes No**

**If yes, name(s) _____**